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STUDY PROJECT

A CONSOLIDATED MILITARY HEALTH CARE SYSTEM

BY

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USAWC CLASS OF 1992

U.S. ARMY WAR COLLEGE, CARLISLE BARRACKS, PA 17013-5050

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION UNCLASSIFIED	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION / AVAILABILITY OF REPORT APPROVED FOR PUBLIC RELEASE. DISTRIBUTION IS UNLIMITED.
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S)	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION U.S. ARMY WAR COLLEGE 6b. OFFICE SYMBOL (If applicable) AWCAB	7a. NAME OF MONITORING ORGANIZATION
6c. ADDRESS (City, State, and ZIP Code) ROOT HALL, BUILDING 122 CARLISLE, PA 17013-5050	7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING / SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
A CONSOLIDATED MILITARY HEALTH CARE SYSTEM

12. PERSONAL AUTHOR(S)
DAVID E. JOHNSON, COLONEL, U.S. ARMY

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Individual Study Project	FROM _____ TO _____	1992 MAY 1	34

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

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20. DISTRIBUTION / AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION	
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT ☐ DTIC USERS	UNCLASSIFIED	
22a. NAME OF RESPONSIBLE INDIVIDUAL DR RICHARD A. GABRIEL	22b TELEPHONE (Include Area Code) 717/245-3022	22c. OFFICE SYMBOL AWCAB

DD Form 1473, JUN 86 *Previous editions are obsolete.*

USAWC MILITARY STUDIES PROGRAM PAPER

DISTRIBUTION STATEMENT A: Approved for public release; distribution is unlimited.

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1 May 92

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ABSTRACT

AUTHOR: David E. Johnson, Colonel, US Army

TITLE: A Consolidated Military Health Care System

FORMAT: Individual Study Project

DATE: 1 May 1992 PAGES: 32

CLASSIFICATION: Unclassified

The desirability of centralization of military health care functions has been argued for repeatedly since World War II. The arguments for and against such centralization have not changed significantly over that period, but the military, social, and Congressional climates have changed such that a considerably larger audience is currently convinced of the advantages potentially offered by consolidation. As one cited review notes "a general consensus [exists] among DOD officials (excepting the ASD(HA) and the Surgeons General) and other observers that the military health services system would benefit from increased consolidation and more centralized management." This paper begins with an analysis of those arguments. Should such a unification effort be found desirable, a model of such an organization is offered. The impediments and secondary effects of such a reorganization are significant and are therefore explored; and some preliminary steps necessary to a consolidation effort are suggested.

INTRODUCTION

The basis for the current manpower status of the military Medical Departments is the rationale of a "no-notice" war on a grand scale. The logic assumes that the capability to mobilize either the reserve component of the military or the unmilitarized portion of the national economy will take an extended length of time. Therefore, enough forces need to be readily available to support the military at war through this waiting period. Recent changes in Europe have vacated the "bolt from the blue" scenario as a basis for force structuring for the military. In addition, Operation Desert Shield proved that reserve forces are available in a timely manner if a moderate, or larger, military effort is needed. The logic should therefore follow that the active duty military medical force needed in the future should only be that necessary to respond to a peacetime engagement requirement. This would parallel the yardstick being used for tailoring the remainder of the American defense establishment.

Over the last 25 years, however, the real mission statement for the Army Medical Department, indeed that for the entire military medical network, has gradually become transformed. Originally dating from the need for providing care to soldier's families undergoing the isolation of the frontier garrison life(1), the permissibility of using active duty medical personnel to treat civilians has become the obligation to treat them. Instead of "organize yourself to support the missions of the

gunfighters (and on a space-available basis, take care of other federal beneficiaries)," the medical mission requirement has become "take care of as many federal beneficiaries as possible (and on-call respond to the needs of the gunfighters)."

Two examples illustrate the current situation. During the mobilization for Operation Desert Shield, when it became obvious that active duty physicians would have to be pulled from peacetime beneficiary commitments, the Army Chief of Staff ordered the Army Surgeon General to see that activated reserve physicians replace mobilized active duty physicians on a one-for-one basis. The peacetime mission had become a required mission(2). The other Service's sent the same message to their medical establishments. Because of their organizational structure, the formulation was a more complicated directive than in the Army.

Second, when the Congress mandated significant force reductions in the Department of Defense (DOD) between 1990 and 1995, the same mandate prevented reduction of medical assets below 1989 levels. That is, inexpensive health care for an enfranchised population took priority over the matching of medical capabilities to the supported force structure(3). Since the Army as a whole will be reduced at least 25% from 1989 levels, if those directives hold, by 1995 the Army Medical Corps (physicians) will be larger than any of the branches of its supported gunfighters. The Medical Department (physicians plus nurses, veterinarians, etc.) will contain 23.5% of the entire Army officer corps.

Since 1947, at least two dozen separate high level (military secretariat and above) studies have examined the military medical system with relatively consistent recommendations(4). The conclu-

sions routinely give token acknowledgment to the unique aspects of each Service, then they have difficulty elaborating rationales for the lack of distinction between the health care provided by the Medical Departments of each Service. In particular, they emphasize the similarities in the provision of peacetime health care to the vast majority of DOD beneficiaries who do not wear a uniform. The majority have recommended, if not total, at least some degree of unification. These recommendations have either been compromised into benign impotence or simply ignored. Recent Congressional interest and concern in this area have, however, resulted in an accretion of centralized power in the Office of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]). New authority has included virtually total budget authority and a strong health care policy directive position(5). The DOD is probably edging closer to the formation of a "Defense Health Agency (DHA)" than it has ever done before in its existence. Knowledgeable observers have predicted full implementation of a DHA by 2005(6). The latest of those previously noted studies, submitted in September 1991, included the frank acknowledgment that "guidance from the ASD(HA) indicated that creation of a single entity (i.e. a DHA) would be the only acceptable proposal"(7).

The propriety of the military as a public service medical establishment can be argued internally, but prudence suggests that the military assume that this is the will of the American people. As such, it behooves the Department of Defense to attempt to arrange the accomplishment of this mission requirement in the

most effective and efficient manner possible. The purpose of this paper is to explore the arguments used for and against the increased sharing of common missions between the Services. In addition, it will examine one possible medical organizational structure aimed at the effectiveness and efficiency demanded in the 21st century American military force.

THE ARGUMENT AGAINST A COMPOSITE MILITARY HEALTH CARE SYSTEM

Opposition to a DHA historically revolves around three basic arguments. The first is that removing the Service Secretaries' authority to manage the health care benefit could adversely affect their ability to manage the force and on their ability to integrate medical readiness. The second contention is that removing the Service Secretaries' authority will also reduce their flexibility in trading off resources between medical and non-medical uses. Since the current blending of medical and non-medical military functions varies among the Services, the impact of this argument likewise varies among the Services. The third argument deals with the nature of the doctor-patient relationship. It suggests that the physician who is wearing the same uniform gives to the patient a beneficial feeling of comradeship, or of working together for the same goal. This kinship would be weakened by placing the servicemember in the hands of either a civilian physician or a representative of an alien entity (i.e. another Service). A fourth argument, of recent origin, is that the disruption inherent in the potentially sizable reorganization could deflect focus from an overriding concern to carry out the

Coordinated Care Program(8).

In response to the first argument, it can be noted that the Services now have extremely limited discretion on the medical aspects of management of the forces under their portfolios. Benefits and beneficiaries are largely a matter of law rather than discretionary regulation, and combat support medical units are carried in a cadre status except when actively engaged in combat. Regarding the peacetime provision of health care, the Service's elective capabilities are limited to how much or how little in-house care will be provided. If insufficient health care capability is provided, beneficiaries can, and will, seek care at the door of another Service or will avail themselves of their Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) entitlement and send the bill to the home Service.

Wartime health care beyond the second level of triage is relatively uniform in policy between the Services(9) and increasing uniformity in equipment and personnel qualification are continuing projects(10). Very few medical units are maintained in peacetime with their complement of professional personnel. These individuals are expected to arrive just-in-time for mobilization and, in most cases, have neither trained with the unit nor been associated with the planning of the employment of that unit prior to mobilization. Where they come from is usually considered immaterial to the unit, and a matter better given over to central direction. In Operation Desert Shield, Reserve medical units that had trained together were routinely disbanded and the professional personnel used on an individual basis in units elsewhere in

the system(11). Active duty personnel were likewise distributed with individual professional credentials as the single criteria of assignment and minimal attention was given to current or prior unit experience. Personnel management and career development, in some areas, do vary between the Services. Given the basic equivalency of professional credentials, interservice transfer of the dissatisfied medical officer is a more functional option than for other officer branches. Service-specific personnel management, operational doctrinal formation, and command and control in combat, however, have rarely been envisioned as suitable subjects for unification and, under most proposals, would be continued as they are now.

The second argument, that of a reduction of budget flexibility, is valid, but no longer relevant. The Services have used medical expense budget authority with such looseness that the Congress has directed that accountability be seated in a single centralized position(12). A vivid example is that of the CHAMPUS payment account. The Army, as well as the other Services, has consistently (7 years running as of 1991) underestimated CHAMPUS expenses, requiring a supplemental request to Congress for money which it has little choice but to approve. The logical assessment is that this account was purposely undervalued to allow application of the eventual amount of the supplemental request to non-medical purposes. Having exhibited a preference for combat equipment in lieu of support equipment, the Services' commitment to medical readiness has been challenged by both DOD and Congress. With the strengthening of the ASD(HA), the Service Secretaries have already lost what authority they previously enjoyed in this

area. The flexibility to tradeoff some resources between medical and non-medical uses still exists, but the major part of that flexibility has been shifted to the Office of the Secretary of Defense.

The third argument, that of identification of the physician and the patient as being members of the same group, has a great deal of subjective validity. Complaints about the handling of their medical care are much more frequent from active duty personnel and their dependents when undergoing treatment in the facilities of another Service(13). There often is a feeling of discrimination (sometimes founded), and the built-in loyalty to one's own team or side is lacking. Much of that inherent bond has been weakened over the past 10 to 15 years, however. This has occurred largely because of the large increase in the number of civilian practitioners in military facilities and the high proportion of retirees whose care is provided on a geographic rather than an organizational basis. An increased level of cross Service assignments and a higher reliance on outside civilian care arrangements than has been evident since the Second World War have also broken up much of the Service specific environment within the military medical facility. The exigencies of an increasingly litigious constituency have also contributed much to breaking the soldier-soldier bond that has historically been one of the strongest aspects of a military medical service. More and more, both sides of the relationship are wary of the other and an increasingly formal "professional" relationship is becoming the norm, at a loss to both sides. Most military medical facilities,

however, do have a specific Service identification and there would be a value lost by changing that identification to that of a generic military medical organization. A smaller value would be gained, however, in the removal of the identification of the facility as belonging to either a competitor or an antagonist.

The last argument is relatively new and has two elements. One is that reorganization would be disruptive and, second, that it would be untimely given higher priorities. That reorganization, or any real change, would be disruptive is given. Fear of improvisation is natural in any sizable organization and is substantially less appealing in as inherently conservative an organization as a Defense establishment whose basic mission is the "preservation" of the way of life of a nation. Skepticism about disruption has been the major contributor to the series of half-measures taken in the past. An example is the stillborn Defense Health Councils formed in 1976 and 1982(14), which have allowed Service hampering of any real innovation. Precedents do exist for the acceptance and utility of a radical kind of a rearrangement, the Defense Logistics Agency or Special Operations Command for example. The removal of medical assets from the individual Services, however, would involve much larger transfers than have been experienced in 40 years. The magnitude of the process has been described, albeit for emotional impact, as analogous to "redesigning and restructuring the United States Marine Corps"(15). The Army, as an example, has not experienced the instant removal of nearly 20% of its officer corps since the Air Corps broke out as a separate Service. The Army, however, because its medical assets are largely organized functionally,

would find it easier to break off this piece than, for example, the Air Force for whom medical assets are more integral to its field activities. On the other hand, each of the Services will experience a significant force reduction over the next few years under any circumstance. The processes and procedures designed for handling the routine reduction could ameliorate the trauma of developing those procedures for the secession of a part of the organization.

The argument continues that the Coordinated Care Program (CCP) is of such priority as to require all of the intellectual and organizational vigor of the various medical services, and that reorganization would not be timely until that has been completed. The CCP is a multi-faceted plan which holds the best promise for the future control, if not containment, of the military cost spiral affecting health care generally over the past 30 years. The ASD(HA) is a primary participant in the policy formulation, political support acquisition, and implementation oversight of the program. Complete implementation of CCP is at least 3 to 5 years in the future, and delays are more likely than not. Like the development of a DHA, the CCP is broaching untested organizational responsibilities, but unlike DHA is attempting to incorporate untried technologies, mainly information management systems, as well(16). If there would be a significant compromise of the CCP as a result of unification efforts, the Military Services may be deprived of a potential monetary savings derivable from the expected benefits of CCP. The physical interference between the two programs is minimal since they are approaching

separate aspects of the health care system, but they will affect the same people and, the same offices would be accountable for the completion of both programs. In my opinion, it is likely that some program or other could, and would, always be brought forward to exemplify the difficulty in doing the reorganization at that specific time. The CCP is the available program in the early 1990's.

THE ARGUMENT FOR A COMPOSITE HEALTH CARE SYSTEM

The argument for a consolidation of health care services always begins with efficacy, but gains attention primarily when ending with money. In many areas, both geographic and functional, two or more Services engage in similar activities concurrently. The proximity situation is frequently cited as ipso facto evidence of avoidable redundancy. The largest issue in recent years in this area has been the two coexistent medical centers in San Antonio, TX.: the Army's Brooke Medical Center and the Air Force's Wilford Hall Medical Center. Few argued that there was not enough illness and injury extant in central Texas to keep both hospitals gainfully employed, so consolidation sounded logical. The attempt to unify these institutions fell victim to parochial distrust between the two Services responsible for funding the resulting chimera(17). Indeed, with one caveat, few military facilities are grossly underutilized. The single exception applies to those facilities located in remote areas where there is a lack of other acceptable care. There is a base level of resources, in nurses, medical specialties, and ancillary

support personnel, necessary to provide any quality care. In some areas, the eligible population is not sufficient to fully employ that base level: Hellenikon AB, Greece; Naples NB, Italy; and Ft. Irwin, CA. come quickly to mind. For historical reasons associated with the need to site the bases in remote areas, most of these small, less efficient facilities are located around airfields. At least since the initiation of the all volunteer armed forces, understaffing has usually proven more of a limitation to care than designed in-patient bed capacities(18). Some consolidation is possible associated with base closures and a dispassionate look at the local civilian capability, but the retrenchment will not be large(19).

There is currently little policy effort expended toward the integration of the peacetime and wartime medical missions. In theory, peacetime health care delivery is drill for skills needed under combat conditions, but resources are routinely applied against one timeframe or the other with little analysis about the appropriateness of their division. The apportionment is significantly different between the Services with minimal cognizance of the tradeoffs possible between the Medical Departments(20). A single management entity offers the non-parochial rationalization of such integration.

By consolidation of peacetime requirements under a single entity, personnel requirements will be easier to define and easier to justify as not in competition for the Congressionally limited line slots. A much more coherent identification of the Reserve Component medical needs is possible with a conjoint

organization. For example, it will not matter if the Navy Reserve is understrength in psychiatrists while there is confidence that the Reserve force as a whole has the necessary number of psychiatrists. Similarly, a single entity offers the opportunity to better define that portion of the military mission capable of civilianization with the least detriment to the readiness mission.

Which brings the argument to money. If we have learned anything since the government became involved in underwriting the cost of health care in the 1960's, it is that the demand for inexpensive health care will always outstretch the capacity for its provision. In repeated instances, Congress has written a medical cost blank check by legislation and then been appalled at the amount written in by the beneficiaries. At a best guess, the reduction of active duty strength by 25%, allows an expected reduction of less than 10% in the population eligible for subsidized health care through the military system. The portion to be reduced (i.e. the younger active duty serviceman or woman) is exactly that part least likely to heavily draw on the available medical and dental services. Under any accepted level of medical capability, beneficiary demand will exceed in-house capacity. Redefinition (i.e. limitation) of the medical benefit owed the enfranchised population is the most efficient and effective method of cost avoidance. While increasingly being done in private insurance operations, this approach lacks a great deal of political appeal. Consequently, the current system accepts rationing by access limitation. CCP offers the potential for some degree of control, but cannot promise substantial health dollar

dividends. An increased emphasis on self-responsibility for one's own health, on preventive medicine, and on increased patient education offer expectations of future benefits in both longevity and quality of life. They do not necessarily imply large reductions in eventual medical expenses in a post-industrial society(21).

Tax-payers, as reflected in the stated desires of their elected representatives, are anxious for demonstrable savings as quickly as possible. By an elaborate accounting system, the military can argue successfully that they provide quality health care cheaper than similar care can be provided in the civilian sector. The logical corollary is that there is an advantage in the maximum amount of health care being performed in-house. The savings are largely as a result of the capped salaries of health care professionals and unmortgaged physical plants. This is the basis for the Congressional mandate that reduction of health care personnel will not parallel that of the remainder of the military.

What is less clear is the monetary savings implicit in consolidation. Without putting a dollar value on the resultant savings from a centralization effort, a recent DOD review concluded that "major savings can be derived from staff consolidations; more efficient catchment area management, particularly in overlapping catchment areas where there is major potential for cost savings; better management of cost tradeoffs between the direct care system and CHAMPUS; and better use of underutilized direct care capacity"(22). Representatives John P. Murtha and

Ralph Regula, citing the Grace Commission among others, suggest that the expected level of savings due to consolidation would be on the order of 225 million dollars per year(23). This, however, represents only about 2.3% of the military direct care budget and approximately 1.7% of the total DOD health care budget. This dollar savings is probably within the accounting discrepancy of different budget evaluation systems and is certainly within the year-to-year variance of the medical budgets of the individual Services. Their expected savings presuppose a significant reduction of redundant levels of bureaucracy by a DHA, a condition contingent on the final appearance of the resultant composite system.

A MODEL HEALTH CARE AGENCY

If, either in the name of efficiency or under the label of political expediency, the DOD does adopt a consolidated institution for the provision of health care, the shape of that organization needs to be anticipated and examined. Alternative appearances of that unification effort range from a single command and control system with a decentralized and Service-specific operating system (a minor modification of the current system), through a separate unified command or defense agency, to a separate service. Each variation has it's advocates and benefits and it is not clear which specific structure will finally evolve(24). The most likely, or perhaps least unacceptable, alternative is probably that of a defense agency subordinate to the Assistant Secretary level of the DOD. It would meet the stated wishes of Con-

gressional critics of the current system and could also maintain, to some extent, the uniform-specific orientation of the medical personnel critical to the Services. Precedents exist in the form of the Defense Logistic Agency, Defense Nuclear Agency, Defense Legal Services Agency, etc. This formulation poses the mildest threat to the integrity of the Services, allowing that portion of the operation integral to the Service mission, in this case combat support medical care, to be maintained by the Service and to be responsive directly to the line.

The Defense Health Agency as envisioned, is charged with command, control, and accountability of all DOD health programs associated with peacetime delivery and wartime support. It includes facilities, personnel, and funding instruments necessary for meeting the health care responsibilities of the Secretary of Defense as defined by the executive and legislative authorities of the United States. As a Combat Support Agency as defined under public law (10 USC 191), its authority is derived from the responsibility of the Secretary of Defense to provide for the performance of activities common to more than one Military Department. The Director, DHA, is a flag officer and the senior medical officer in the DOD.

A Defense Health Agency carved out of the current medical force structure would be responsible for a direct care system of 168 hospitals, 643 medical clinics, and 429 dental clinics. This system is supplemented by CHAMPUS and other necessary care provided at civilian institutions, but funded through DOD. It would include a medical, nursing, and public health graduate school, a

large in-house research and development organization, and extensive ties to national and international medical systems. This would not include the medical activities organic to combat units, although the ASD(HA) has policy and budget responsibility for them as well. In 1989, this system, direct care and CHAMPUS, supported 1.2 million hospitalizations and almost 56 million outpatient visits. There are nearly 9.5 million enfranchised beneficiaries. The current cost of DOD medical care is estimated at 13 billion dollars per year, approximately 5% of the total DOD budget(25). Since this represents the homeland base for support of combat overseas, in wartime there is provision for additional support from the Department of Veteran's Affairs and the private sector health care systems should that prove necessary. Minor variations from the current system will occur over the next few years with various base closures and a drawdown of active forces, but under any foreseeable circumstances this will remain the largest single health care organization in the United States.

A prototypic mission statement for the Defense Health Agency would be on the order of:

> The Defense Health Agency, under the direction, authority, and control of the Assistant Secretary of Defense for Health Affairs, provides worldwide medical support for the missions of the Military Departments and the Unified and Specified Commands under conditions of peace and war. Also provides medical support to other DOD Components and certain Federal agencies, foreign governments, international organizations, and others as authorized. Provides medical services and items of medical supply that have been determined, through the application of approved criteria, to be appropriate for integrated management on behalf of all DOD Components. Furnishes medical services directly for non-active duty beneficiaries and for active duty personnel associated with hospitalization and medical and dental specialist consulta-

> tion, and other support services including veterinary care and food inspection, preventive medicine services, dietetics consultation, mental health services including drug and alcohol abuse evaluation and treatment, and inventory management of medical-specific items of supply for the National Defense Stockpile Program. Administers civilian health and medical programs for retirees, and for spouses and children of active duty, retired and deceased members of the Uniformed Services. Conducts training for military personnel in medical disciplines at recognized professional levels and acts as the liaison between the military and civilian medical regulating agencies. Conducts medical research and development concerning conditions of military import and acts as the coordinator of such medical research with civilian and other military research efforts.

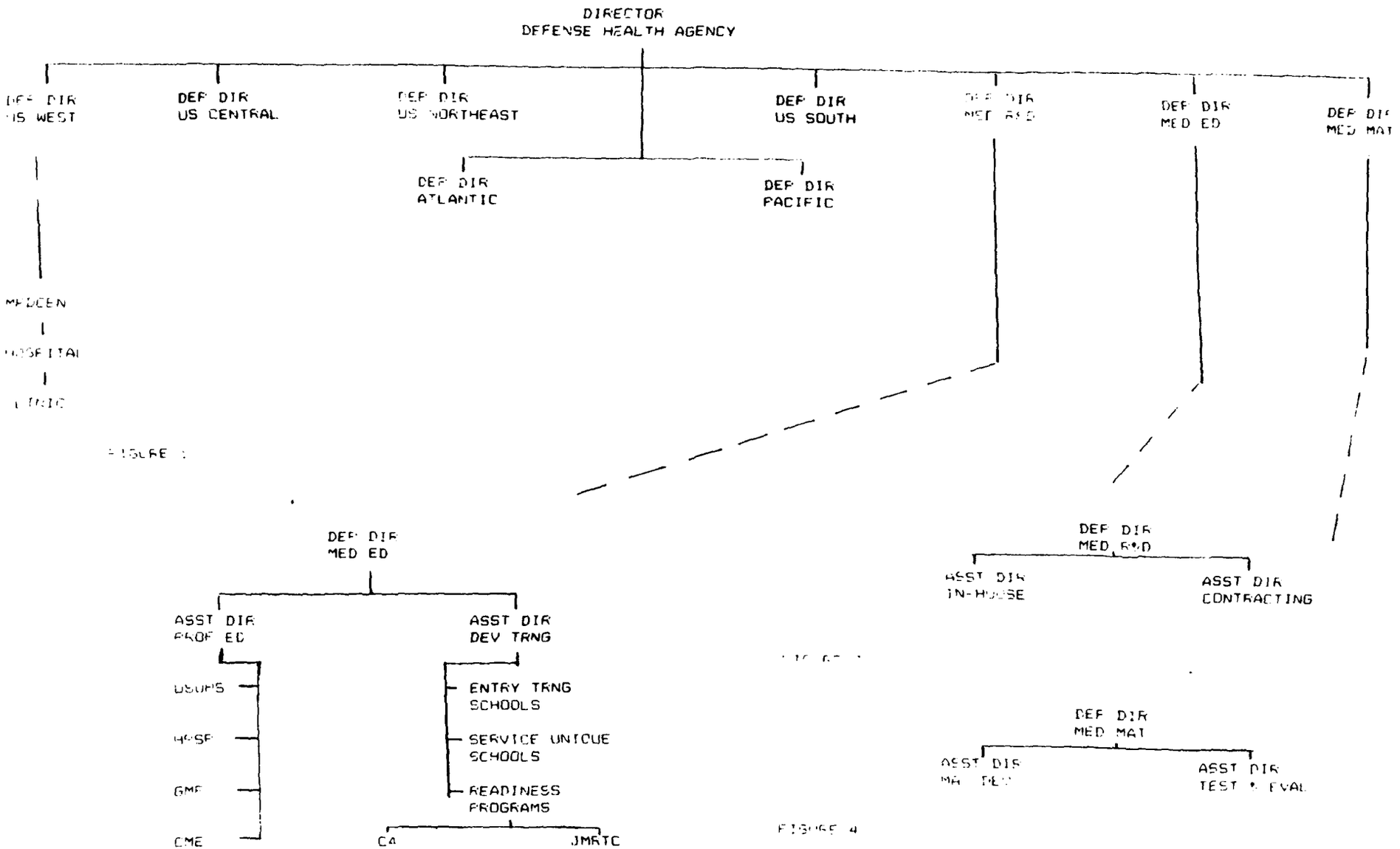
Notably lacking in the above is the personnel management functions, the conduct of medical services to active duty personnel short of hospitalization or specialty care, warfighting doctrine development, and the command and control of medical assets organic to combat units. While there will be obvious involvement in these areas, and the ASD(HA) has policy and budgetary responsibilities in these areas, these functions are left to the Military Departments with oversight through the separate Surgeons General. There must not be a total split between the peacetime and the wartime medical missions with, for example, the beneficiary mission performed by a DHA and the readiness for combat mission totally given over to the Services. Since the same uniformed medical care provider must be prepared for both missions, training for both missions must not be contingent on his or her assignment of the moment. In addition, resource tradeoffs between the two missions need to be coherently rationalized by one office.

Because of the above dimensions of the military health care

network, span of control becomes the obvious first difficulty in defining a centralized structure. A prototypic organizational chart is at Figures 1 through 4. A system based on Service Components, as in a Combined Command, is specifically rejected. Service orientation is inimical to the primary intent to develop joint relationships that accomplish the health care mission in as efficient a manner as possible with optimal opportunities for economies inherent in a consolidated system. A set of six geographically defined directorates, each under a DHA deputy, conduct the day-to-day medical services and activities. Geographical definition is required given the necessity of adjudicating the considerable overlap in many of the current hospital catchment areas, an operation severely inhibited by a Service Component orientation to the Agency. Four of these directorates cover the continental United States (Figure 5). One covers the areas defined by the Atlantic, the Southern, and the European Commands (labeled "Atlantic" in Figure 1) and the remaining geographical directorate covers those areas defined by the Pacific and Central Commands (labeled "Pacific").

Within each geographical directorate, a subdivision into specific catchment areas gives the responsibility for coordination of all care, civilian as well as military, to a single hospital-based military medical authority. There may be multiple military medical facilities within a catchment area and there will be multiple civilian hospitals, but a single authority allows the maximum coherence of care within the area.

The military medical authority must be responsive both to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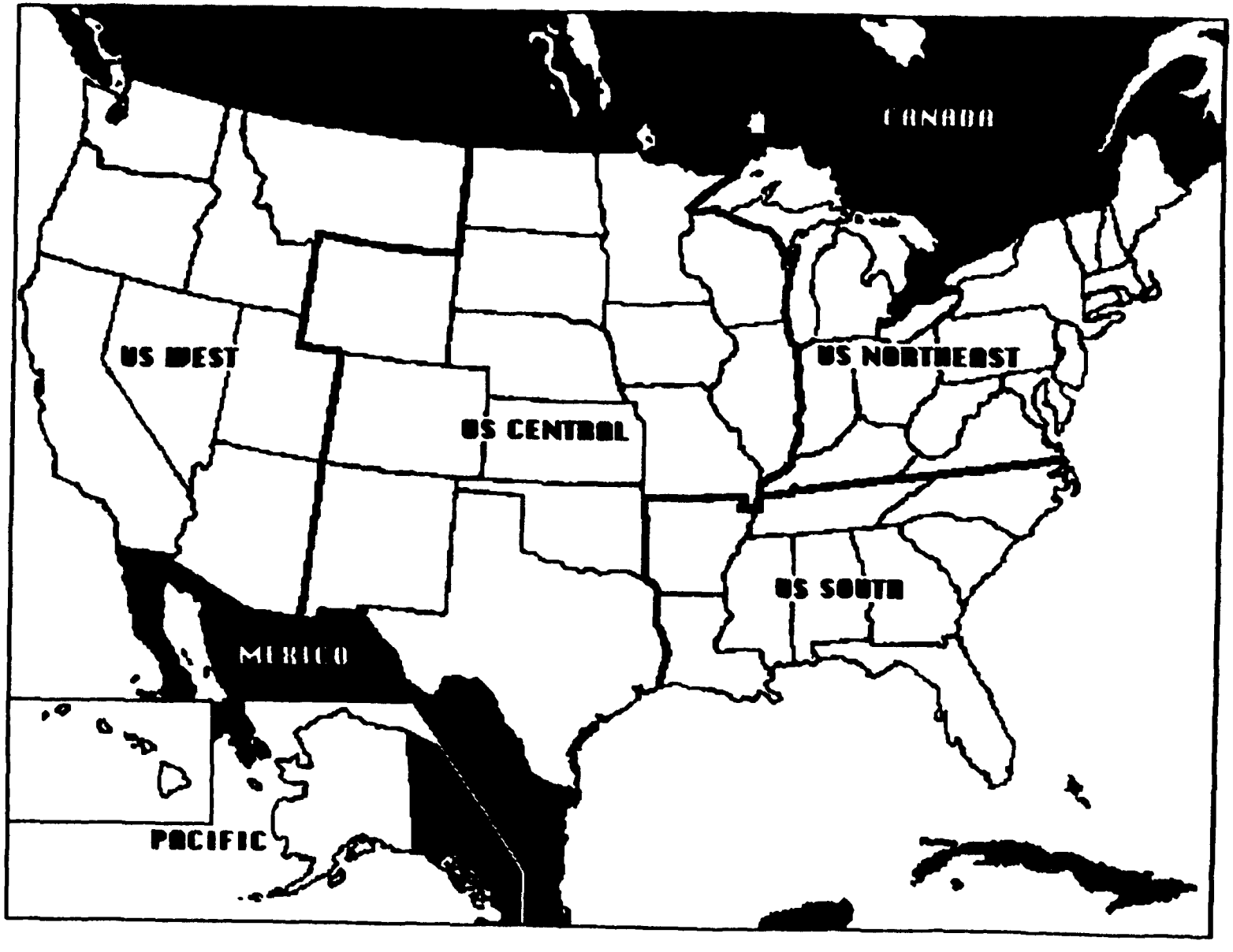
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US WEST
US CENTRAL
US NORTHEAST
US SOUTH
MEXICO
PACIFIC

FIGURE 5

the line commander with overall responsibility for the corresponding geographic area, as well as to the DHA, and evaluation practices are established accordingly. For example, both the military medical authorities at Fort Hood, TX. and Galveston NAS, TX. have responsibility to the Army and Navy commanders respectively of those installations and are evaluated and rated by them. This gives the line commander limited responsibility for the performance of the medical treatment facility and an incentive to actively ensure adequate responsiveness of the medical detachment to the line and the provision of adequate installation resources to the medical detachment when necessary. Further evaluation and senior rating, however, is performed by the deputy director responsible for the DHA geographical directorate, in this case for example, an Air Force officer at Lackland AFB, TX.

In general, all medical personnel, not assigned to units organic to the local combat unit are under the command of the installation military medical authority. Some activities of personnel assigned to combat units is also under the direction of the installation military medical authority, who is responsible for the physician's credentials evaluation and the scope of his clinical privileges. An example of this may be the care provided to the unit commander's juvenile daughter by the battalion surgeon. A military officer can move relatively easily from directorate to directorate within the DHA, and into and out of the DHA, during various assignments. With the majority of positions being within the DHA, however, most officers will spend the largest portion of their careers within the DHA.

Separate functional directorates are responsible for Medical Research and Development, Medical Education (both generic medical and military-medical), and Medical Material. In each case, the functional deputy director has responsibility for the oversight of the activities of all DOD agencies in his or her functional area. The Naval Medical Research Unit in Cairo, the Brooke Air Force Medical Laboratory in Texas, and the Armed Forces Research Institute of Medical Sciences in Bangkok, for example, all report to the Medical Research and Development Directorate.

SOME ORGANIZATIONAL IMPLICATIONS OF CONSOLIDATION

As noted earlier, because of their current configuration, the various Services will find the transition to a DHA of differing complexity. While the initiation of the DHA will start on the basis of the aggregated peacetime medical components of the three Services, the Air Force and, to a lesser extent, the Navy will find that their smallest hospitals will come under the greatest pressure for consolidation or downgrading to outpatient clinic status. In addition, the personnel for the direct combat support mission may no longer be physically located on the base or assigned to the base hospital as was sometimes the case previously.

Of the three Services, the Navy has the least capability for its own dependent and retiree care and the Army has the most. Since the Services will still be responsible for personnel management of their uniformed members, there will be considerable pressure to rationalize those patient/provider relationships

according to the number of beneficiaries associated with each Service. There will also be considerable pressure to match the capabilities of primary care physicians (the "gatekeepers" under the CCP) between the different Services. Both the Navy and the Air Force use General Medical Officers (physicians with no training beyond internship) and short-course (less than six months) trained flight surgeons more extensively than does the Army. Since the most straight forward solution to both of these inequitable conditions entails specialty training, the Navy and Air Force will probably end up with more people in graduate medical education programs. This will result in higher retention levels than they have previously experienced, but also higher personnel costs.

The Services, as the personnel cost bill-payers, will recurrently fight for maximal reduction of the "retiree care overhead," at least in their personnel accounts. The DHA will be the proponent for maximal in-house medical capability, pleading support for its training programs and cost efficiencies within military facilities. In response to the mandate to exempt medical personnel from the projected drawdown of forces, this argument is already ongoing with the ASD(HA) and Congress in the role of in-house capability advocates. Under a DHA, because of better information available for analysis, the Services will have a stronger case than they have now for civilianization (a la CHAMPUS) of the medical personnel requirements in excess of their operational demands.

The Air Force expects a much greater degree of involvement of its medical personnel in the day-to-day operation of the wing

than does either the Navy or the Army. This is part of the Air Force culture, probably derived from both the enhanced medical participation in the physiological aspects of aviation as well as the fact that much of that planning involves the airfield itself with its fixed medical facilities. In contrast, both the Army and the Navy go elsewhere to fight with only a marginal reliance on the fixed installation. In addition, only a minority of line Army and Navy personnel are as involved in recurrent routine physical examinations and assessments as are flight personnel. During the retrenchment necessitated by the loss of the largely draftee Medical Departments in the early 1970's, the Air Force steadfastly maintained its wing medical organizations to the detriment of its medical centers and training programs. The Army took the opposite tack, maintaining the medical center associated training base while leaving the vast majority of the battalion, brigade and division medical positions unfilled. (The Navy just bumbled along, eventually losing both portions of its structure.) A DHA, with its strong orientation to the straight practice of medicine, will logically strengthen that portion of the structure most concerned with quality health care provided to the individual patient. While the specific role of the aviation medical officer will not change, and the Army and the Navy do involve their organic medical personnel in some operational planning, the character of a medical system built around the pilot/flight surgeon relationship is, unfortunately, likely to be diluted.

Both the Navy and the Air Force place non-physicians in command positions of some medical facilities. The Army will have

to follow suite. The Army has a better, although not ideal, preparatory program for its physician leaders than does the other Services. They will have to follow suite. The Navy's specific career track program for physicians interested in medical management may be the optimal model for the entire system. Recurrent leadership assignments for the physician-manager would more closely approximate the line career pattern. The other Services' penchant for assigning senior O-6's (and occasionally O-7's) to their first command billet may not be the best way to find medical leaders.

The Army has the largest Military Medical Department. It also has the majority of the medical centers, the specialty training programs, and the teaching faculties that will provide the basic skeleton for the DHA organization. The current Army organization most closely approximates the resultant configuration of the DHA, consequently, the Army has the largest number of personnel familiar with working within such a system. During the transition process from the current system, extensive effort will be required to assure Navy and Air Force personnel that complete domination of the Agency by "green-suiters" will not occur. Some affirmative action programs, especially at the senior staff levels, may be necessary to accomplish this.

PRELIMINARY INITIATIVES TOWARD THE FORMATION OF A COMPOSITE HEALTH AGENCY

Several management areas need to be rationalized prior to the initiation of the DHA. Some of these are recognized, a search

for solutions is ongoing, and may only need a mandated completion date. Others have historically been accepted as distinct between the Services and uniformity will have to be directed. Uniformity will be necessary in the identification of the capabilities of comparable personnel. Physicians, nurses, and most allied health professionals can be distinguished using accepted civilian standards. For example, a gastroenterologist is a gastroenterologist regardless of his uniform and an ICU nurse has a specific set of capabilities. The capabilities of enlisted medical personnel, however, do not have the same standards and are used very differently between the Services. Everything else being equal, an Army medic is given considerably more independence than his or her Air Force counterpart. The incongruence between the Army field medic, the Navy corpsman, and the Air Force independent duty medic requires formal adjudication. Unfortunately, the commonality will probably be at the least degree of autonomy, limiting a significant resource that the Army has counted on for completion of its mission. This verdict may also effect what can be expected of the enlisted combat medic or corpsman on the battlefield.

While not mandatory, there should be a rationalization of the specialty pay given to a medical specialist regardless of Service. Currently, a flight surgeon in the Air Force makes more than he would were he in the Navy which is more than if he were in the Army.

There needs to be a uniform identification of the manning and cost requirements for a specified workload. The present Air Force personnel requirements (number of nurses per 100 patient-

days, for example) is considerably higher than for the other Services. The need for adjudication of these standards has been recognized and is an ongoing project.

A population definition system needs to be applied to all military beneficiaries to account for the variation in the size of catchment areas. The current system (Defense Eligibility Enrollment Registry System [DEERS]) is incomplete. While it can be used to identify eligibility for the individual, it cannot presently be used to identify the population served by a medical facility. When the cost standards and personnel requirements are rationalized, and the beneficiary population defined, an eventual resource distribution system based on capitation of the population served in a given area can be applied. This will reduce much of the frustration of partial and incremental budgets at the local level based on higher headquarters needs to maintain sizable reserves to accommodate unexpected demands. Available resources could also be more fairly distributed.

There will need to be a comparable accounting system for the equitable distribution of available funding. The Army has the most sophisticated cost identification system (the Uniform Chart of Accounts and Performance Reporting System [UCAPRS]) which will either be adopted by the others or modified for adoption by all. This may be the single most difficult, and expensive, of the preconsolidation measures necessary.

Overarching all the other preconditions for establishing a centralized health care system is a need for a centralized budget preparation and execution system. Service peculiar requirements need to be accommodated, but duplicate programs that now diffuse

accountability and contribute to redundant actions will have to be eliminated. This measure both offers the best opportunity for quick monetary savings and the best opportunity to gain control of a new and inherently ungainly bureaucracy. While such a system does not currently exist, Congress has directed and challenged the ASD(HA) to develop such a methodology with or without a consolidated health network(26).

Such a fiscal management tool will be necessary for establishing a DHA. Once in place, however, the argument will be raised that such a system is, in itself, enough to meet Congressional mandates and thereby obviates the need for further consolidation(27). Half-step arguments are to be expected by unification opponents throughout the consolidation process, but this one will require contention that further efficiencies may be realized with continuation of the process of centralization.

Many of the accounting and rationalization systems required for a DHA are on the planning agenda or in development. They were not designed for a unification process, but they are designed to be uniform across the DOD. These requirements, in themselves, need not be a limitation on the initiation of a DHA process.

CONCLUSION

The lack of a large external threat has removed much of the rationale for a large standing military force. The military medical services have proven, however, that they can provide quality health care in a cost efficient and conscientious manner.

For a population largely lacking other health care enfranchisements, the peacetime medical system is viewed, by both bill-payers and potential patients, as being an asset worth preserving even as the Defense establishment as a whole is being reduced. The idea of limiting to a unit only those things that are needed always, and "pooling" those assets needed to meet peak loads or unusual or extreme circumstances, in this case combat casualties, has been inherent in the American military system for half a century(28).

Any conclusion from the arguments for and against a composite health care system will never be totally persuasive for everyone. The subjective weight given to each of the rationales, pro and con, by each decision-maker, will determine that individual's determination about the desirability of such a system. A proponent of the existing conditions can honestly argue that it is inappropriate to "fix" an unbroken system that has proven that it can provide health care with a quality at, and usually exceeding, any comparable civilian standard at a cost demonstrably below civilian levels, both in absolute dollars and in rate of inflation(29). An opponent of the status quo can honestly claim significant room for improvement(30). Convincing and compelling for the author personally is that: 1) insistence on Service parochial interests is inefficient and eventually will be counterproductive in terms of public support for their armed forces; and 2) the next decade represents the first period, since the late 1940's, when there coexists a public, a military, and a political will to accommodate change. General Omar Bradley took advantage of that last conjunction to reorganize and refurbish

the medical services of what is now the Department of Veteran's Affairs(31). It's time for this generation to begin to look at, and prepare, the arrangements necessary to go forward with a consolidated military health care system.

NOTES

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